Policy and Procedure Milwaukee County Behavioral Health Division SAIL	Date Issued 12/17/09	Section SAIL	Policy Number QA - 11	Page 1
	Date Revised 8/20/2012	Subject: CMHC Progress Notes/Documentation for Mental Health CBRF/Group Home Providers		

1. POLICY:

The main purpose of progress notes/medical record documentation is to serve as a basis for planning and continuity of client care. Progress notes are required as part of the chronological record of care and it is the expectation of the Community Services Branch of Milwaukee County Behavioral Health Division that the Mental Health CBRF/Group Home staff is responsible for maintaining current, complete, and accurate progress notes. Providers are responsible for following all applicable case record and/or documentation requirements as specified by: the Wisconsin State Statutes and Administrative Codes.

2. PROCEDURE:

1. All medical record entries shall be timed and dated. Medical record entries shall be made promptly.

2. If a period of time has elapsed beyond the day of direct client contact, the late information shall be entered, documenting the actual date and time of the entry. Make reference to the time/date of the contact that is being documented (e.g., "12/15/07 – 1400 – Late Entry – On 12/13/07 at approximately 0900, the client was seen at his apartment…").

3. The required *minimum* standard shall be for progress notes to be finalized and in the medical record **within 72 working hours** of client contact. The *preferred* standard is within **24 hours**.

4. Exceptions to the 72-hour allowable minimum standard are situations where the *No Contact Case Management Policy* applies, and in crisis situations. In these cases, the expected standard for documentation shall be **24 hours**.

5. The above documentation requirements apply only to *direct* services (i.e., face-to-face or telephone contact with patient) versus indirect services (i.e., collateral contacts, business-related phone calls, etc.). However, even in the case of indirect service, there are certain situations where collateral information may be of such importance that providers are advised to apply the higher, direct service documentation standard.

6. Programs are reminded of the importance of timely documentation for risk management purposes and are strongly recommended to exceed the minimum standard when there are changes in clinical condition.

7. Documentation requirements apply to direct services (i.e., face-to-face or telephone contact with client) and indirect services (i.e., collateral contacts, business-related phone calls, etc.) or any client-related activities done on the client's behalf.

8. Progress notes must be reflective of the client's movement towards recovery, changes in level of care, changes in the client's treatment plan, service plan, or goals, any additional services

needed by the client, and discharge from services. Group Home Providers must vary the content of the client's progress note documentation in each weekly entry and providers may not have the same progress note documentation for a client from week to week.

9. CMHC Progress Notes Documentation Requirements: The CBRF/Group Home Provider is expected to complete a progress note weekly in CMHC on each client in the group home setting. This progress note documentation must be done in conjunction with CMHC entry for payment, as payment for services will not occur to the agency if there is no corresponding progress note entry for that week in CMHC. The progress note entry must include the author's name if someone other than the individual completing the progress note entry, enters this information into CMHC.

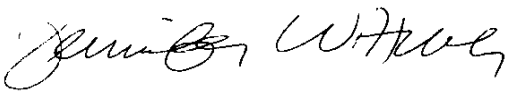
    a. General documentation - progress notes may address any activity in the following life domains: substance abuse, basic needs, social network, family, daily living skills, mental health, physical health, trauma and significant life stressors, use of medications, any significant crisis prevention and management, information from the Crisis Plan, Summary of Clinical Supervision session, legal status, commitment, or any other information pertinent to the client's care.

    b. Discharge - Progress notes shall include a brief discharge summary including the episode closing reason, aftercare plan, and any circumstances associated with the discharge (i.e. client's progress, etc).

    c. Weekly Entry- weekly progress notes in CMHC begin on Monday and end on Sunday. Progress note and payment entry for this weekly time period must by complete by Friday of the following week. Payment entry includes the following descriptions:

        i. CBRF Day-check if client present at the group home any time during the day.
        ii. Crisis Per Diem Entry- check only if the client is present at midnight on that day.
        iii. Leave Day- for CBRF day, check if client absent the whole day and for Crisis Services Day, check only if client not present at midnight on that day.
        iv. No Entry- check if client has been discharged from the group home and is no longer at the facility.

    d. RAP (Registration/Assessment Packet) documentation must be completed in CMHC at regular required intervals (intake, every 6 months, and at discharge) for all clients' residing in the mental health CBRF/group homes.

Reviewed & Approved by: 

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